U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 October 2002

In the matter of	)	
	)	
MARK MINOTIS	)	
Claimant	)	
	)	
v.	)	No. 2001 LHC 0823
	)	
NASSAU TERMINALS, INC.	)	OWCP No. 06-180408
Employer	)	
	)	
and	)	
	)	
DIRECTOR, OWCP	)	
Party-In-Interest	)	

Appearances: Daniel Glary, Esq.
For Claimant

James F. Moseley, Jr., Esq.
For Employer

Before: JOHN C. HOLMES
Administrative Law Judge

DECISION AND ORDER

This is a claim for medical benefits and additional temporary total disability benefits arising under the Longshore and Harbor Workers' Compensation Act ("Act"), as amended. 33 U.S.C. § 901 *et seq*. A formal hearing was held in Jacksonville, Florida on April 16, 2002. The record was kept open for the filing of the deposition transcript from Dr. Lovejoy and post-hearing briefs. Dr. Lovejoy was deposed on May 15, 2002, and the transcript was timely submitted post hearing and will be identified as "Joint Exhibit 2."

Findings of Fact and Conclusions of Law

A. Background

At the time of the hearing, the Claimant, Mark Minotis, was thirty-nine years old and a

resident of Yulee, Florida. (Tr. 30-31).[1] Claimant began working for Employer, Nassau Terminals, in 1995 as an equipment operator. (E-4.2; Minotis Depo. at 26). On August 25, 1999, at approximately 9:30 p.m., Claimant and his supervisor, Russell Donaldson, were unloading 3,000 pound bales of wood pulp from railcars at the terminal facility. Donaldson operated the equipment and Claimant connected hooks from the machine onto the metal bands of the bales. At one point, Claimant unhooked a bale from the hooks of the machine and Donaldson did not lift the mast of the machine to clear the hooks from the bale. When Donaldson pulled back on the machine, the hooks grabbed back onto the bale, swung it, and dragged it across Claimant's right foot, pinning him up against another bale. When Claimant yelled, Donaldson lifted the bale and backed it off. Donaldson asked Claimant if he needed to go to the hospital, but Claimant was unsure as to whether that was necessary. Donaldson then stated that they would wait until the following day if Claimant's foot continued to ache. Claimant ceased working due to the pain in his foot, but stayed at the terminal for the remainder of his shift, which ended at 11:00 p.m, resting and intermittently attempting to "walk off" the pain. At 6:30 a.m. the following morning, after a painful night at home, Claimant called into work and informed Employer that he needed to go to the hospital. Employer told him to go, and Claimant went to the emergency room at Baptist Medical Center on Amelia Island. X-rays were taken at the emergency room, and Claimant was informed that he did not have any breaks. Claimant was given crutches and advised to stay off his foot for a week and to see a follow-up doctor (Minotis Depo. at 31-42).

Employer referred Claimant to its "company doctor," Dr.White, for follow-up. Mark Balester, Dr. White's physician's assistant, actually treated Claimant. (Tr. 33; Minotis Depo. at 43). Balester diagnosed Claimant with a right foot contusion/crush injury and returned him to work for desk duty only on September 2, 1999. (E-1A). Thereafter, Claimant treated with Dr. Carrasquillo, an orthopaedist. A MRI of the injured foot ordered by Dr. Carrasquillo was positive for a lateral cuneiform, third metatarsal, and cuboid contusion. On November 5, 1999, Dr. Carrasquillo advised Claimant to return to sedentary work only and sent him for pain management. (E-1B). Claimant next treated with Dr. Lovejoy, who, on November 12, 1999, diagnosed Claimant with a right foot crush injury with a bony fusion of the third cuneiform, third and fourth metatarsal and irregularity in the mid foot. Dr. Lovejoy continued to treat Claimant, and on February 3, 2000, Claimant informed Dr. Lovejoy via telephone that he had back pain. (E-1C). Thereafter, Claimant treated with various physicians for right foot, bilateral thigh, and back pain. (E-1D; E-1E; E-1F; E-1G; J-1-Hofmann; J-1-Pohl; J-1-Roberts; J-1-Florete).

Claimant reached MMI (maximum medical improvement) for his right foot injury on June 6, 2000, with a 20% impairment of his right lower extremity. Claimant received temporary and scheduled benefits as a result of that injury. The Claimant now seeks medical benefits and additional temporary total disability benefits from June 6, 2000 through April 16, 2002, for his low back condition, which he alleges has been aggravated by limping due to the compensable right foot injury. Employer responds that no injury to Claimant's back resulted from the August 25, 1999 incident.

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[1]Citations to the record will be abbreviated as follows: Tr.-Hearing Transcript; E-Employer's Exhibit; J-Joint Exhibit.

At the time of the hearing, Claimant testified that he favors his right foot and has back pain which is constant, progressing, and worsened by lying down or leaning against something. (Tr. 34). Claimant has neither worked nor aggressively sought work since his right foot injury. Claimant is a high school graduate with a mechanical background, computer ability, and experience as a supervisor for the public works department of a small Illinois community. (Tr. 72-74, 77; Minotis Depo. at 8-13).

B. Stipulations

1. This is a claim for benefits under the Longshore and Harbor Workers Compensation Act and jurisdiction lies.

2. The Claimant injured his right foot on August 25, 1999, while acting in the course and scope of his employment for Employer. Timely notice of that injury was provided by the Claimant, and the Employer has accepted the right foot injury as compensable.

3. The Claimant suffered a prior low back injury in a motor vehicle accident in Chicago, Illinois in approximately 1979.

4. Claimant's average weekly wage is $595.96, with a compensation rate of $397.31.

5. Claimant reached MMI for his right foot injury on June 6, 2000 with a 20% impairment of his right foot, pursuant to AMA guidelines, which equates to a 14% impairment of his right lower extremity, as reflected by Dr. Hoffman's office note of June 6, 2000 and letter of January 25, 2001.

6. The Employer paid 42.285 weeks of temporary total disability benefits to Claimant, from August 26, 1999 through October 17, 1999, and from November 5, 1999 through July 4, 2000, in the amount of $391.13 per week. The Employer further paid 18.45 weeks of permanent partial impairment benefits to Claimant, based upon an inaccurate 9% impairment of the Claimant's right foot, at the rate of $391.13 per week. The Employer shall pay the additional temporary total and permanent partial disability benefits owed to the Claimant, consistent with an average weekly wage of $595.96, with Dr. Hofmann's MMI date of June 6, 2000, and with the 20% impairment rating Dr. Hofmann assigned to the Claimant's right foot. Counsel for the Claimant waives any attorney's fees owed as a result of the Employer's correction to the amount of past benefits it has voluntarily paid.

7. The remaining issues before this tribunal are:

a) Whether Claimant's low back condition is compensable?

b) Whether Claimant requires further medical treatment for his low back condition?

c) Whether Claimant is owed additional disability benefits as a result of his low back condition and the amount of those benefits, if any.

Should the Claimant's low back condition be found compensable, the Employer contends it is entitled to 8(f) relief once the Claimant reaches MMI for his low back.

C. Medical and Related Evidence

Since the parties stipulated that the principal issue is whether the Claimant's preexisting low back condition was aggravated by the compensable right foot injury, the discussion of the medical evidence is limited to evidence pertinent to Claimant's back condition.

During his May 21, 2001 deposition, Claimant stated that he was in a car accident when he was seventeen years-old, which would have been in 1979, and was hospitalized for a day and a half at McNeill Hospital in Oak Park, Illinois. Claimant recalled that he sustained "some cracks in the vertebras," but did not know how many and could not remember where in his back he felt pain, though he later surmised that the pain was in his lower back. Claimant stated that he only saw a doctor for one follow-up after being discharged from the hospital with a girdle for his back. (Minotis Depo. at 14-16). Claimant further stated that he never made any complaints about back pain to his former wife, Laura, during their marriage which lasted from 1982 to 1989. *Id.* at 5, 11, 16-17. Approximately one year later, at the April 16, 2002 hearing in this case, Claimant stated that he had not received treatment following the 1979 car accident, and declared that his back had never caused him any problems. (Tr. 31-32).

On May 21, 2001, Claimant stated that his low back pain began to bother him in November 1999, elaborating, "I felt it prior to that, but it was just, you know, a dull pain that I could live with." (Minotis Depo. at 49). He was unable to say whether the pain was in the same location as the low back pain which resulted from his prior back injury. *Id*. at 48. He noted that only walking brought on the onset of back pain. *Id.* at 49. At the April 2002 hearing, Claimant reiterated that he first noticed his back pain in November 1999, stating that it "was a slow gradual thing." (Tr. 75-76). Claimant testified that his back pain has worsened over time and is now constant, worsening when he leans back against a chair or lays down. Claimant maintained that he has limped, favoring his right foot, since the August 25, 1999 foot injury. (Tr. 33-34).

The evidentiary record indicates that Claimant first complained of back pain to a physician on February 3, 2000 to Dr. Lovejoy. Dr. Lovejoy, an orthopaedic surgeon, began treating Claimant on November 12, 1999, after referral by Ms. Wiltshire. Ms. Wiltshire performed the medical management of Claimant's case on behalf of Employer's insurance carrier, ARMS Incorporated Workers' Compensation. In a new patient entry form filled out by Claimant on November 12, 1999, Claimant stated that his pain consisted of, "Pain in top of foot and front right side of foot, lots of pain in the morning, pain that shoots up from mid foot up calf to just below the knee, tingling sensation." (J-2 at 20, Deposition Exhibit 2). Dr. Lovejoy reviewed specified medical evidence, examined the Claimant, and diagnosed a right foot crush injury with bony fusion of the third cuneiform, third and fourth metatarsal and irregularity in the mid foot. Dr. Lovejoy did not describe the Claimant's gait

during the examination. Dr. Lovejoy saw Claimant again on December 10 and December 29, 1999. Claimant's only complaints during those visits related to his right foot injury. During his May 15, 2002 deposition, Dr. Lovejoy explained that he would have recorded any back pain complaints, had they been reported, as relevant with regard to possible progression of Claimant's problems. (J-2 at 8-10). On January 19, 2000, Claimant returned to Dr. Lovejoy's office complaining of worsening foot pain and pain in his hip. Dr. Lovejoy noted in a letter to Ms. Wiltshire after the examination, that Claimant's examination and x-rays were unchanged; however, he indicated that Claimant was sent to the "pain clinic" for pain management, suggesting the possibility that Claimant had mild RSD (regional sympathetic dystrophy). In a letter to Ms. Wiltshire dated February 3, 2000, Dr. Lovejoy explained that Claimant had called his office and "wanted to make sure that it was documented that he had mentioned having back pain." Dr. Lovejoy added Claimant's complaint of back pain as an addendum to his January 19, 2000 letter. The records indicate that Claimant saw Dr. Lovejoy once more on March 10, 2000, but neither his back nor hip pain were discussed. (E-1C).

Dr. Lovejoy was deposed on May 15, 2002. (J-2). Besides reiterating his treatment of the Claimant, Dr. Lovejoy opined that the bony fusion in Claimant's right foot would permanently alter his gait. He also opined that the foot injury and change in gait could cause some aggravation of a preexisting back problem, but that without knowing the specifics of Claimant's prior back injury, he could not further speculate with regard to the etiology of Claimant's back pain. (J-2 at 16-18).

Dr. Lovejoy referred Claimant to Dr. Muenz, board-certified in physical medicine and rehabilitation and family medicine, for an electrodiagnostic study for evaluation of persisting problems in his lower right limb on February 18, 2000. The results of that study were normal, showing no electrodiagnostic or clinical evidence of complex regional pain syndrome. Dr. Muenz referred Claimant back to Dr. Lovejoy for continued follow-up care; however, Claimant was referred back to him by Ms. Wiltshire to address Claimant's back pain in the context of a comprehensive back evaluation. The evaluation took place on March 9, 2000. Claimant reported to Dr. Muenz that he had been experiencing back pain for four months. Claimant also indicated that, at age seventeen, he was involved in a severe motor vehicle accident for which he was hospitalized for two weeks. Claimant recalled that he "'cracked three vertebrae,' was at bed rest for a couple of weeks, was given 'a girdle' and was sent home." Claimant further recalled that he had routine follow-up care for approximately six months. Dr. Muenz indicated that, "he [Claimant] tells me that he has always had back problems since then." Claimant reported that "walking provokes his pain." Dr. Muenz noted that , "At his [Claimant's] request, some weeks ago, I ordered a corset for his back. Now, when wearing his brace, he feels '100%' better.'" (E-1D).

On examination, Dr. Muenz noted that Claimant was currently community ambulatory and driving without difficulty. Dr. Muenz noted that Claimant ambulates about the examination room freely, with no assistive devices, is wearing steel-toed reinforced work boots, gets up onto the examination table without difficulty, and dresses and undresses without difficulty. Upon examination of Claimant and review of specified medical records, Dr. Muenz's assessment was: 1) History of significant previous back trauma; 2) Recent flair-up of back pain; and 3) Crush injury to right foot without evidence of RSD/CRPS. He concluded:

> I find no evidence, by history or physical examination, of a new back trauma. Mr. Minotis may have strained his low back recently, while favoring his right lower limb. I do not believe that his complaint of back pain is directly causally related to his right lower limb trauma. I find no clinical evidence of an aggravation of his previous long-standing back disorder. I do not believe that any medical impairment exists. Work status determination has been addressed by Dr. Lovejoy.

(E-1D).

According to a "Contact Form" filled out by Dr. Muenz, on July 28, 2000, at approximately 1:00 p.m., Claimant came into his office and demanded his records and the name of the person who performed his EMG. Dr. Muenz noted that Claimant sounded angry and hostile. Dr. Muenz indicated that he was in the examination room, but that he and his two patients heard Claimant. Dr. Muenz explained that he went to the front desk, assessed the situation, locked the door from the reception area, and asked Claimant to leave the premises or he would call the police. Dr. Muenz stated that, "He [Claimant] turned, walked briskly to the front door, through [sic] the front door open, and yelled, 'I hope you have good malpractice insurance, I don't like being lied to.'" Dr. Muenz noted that Claimant was in no apparent physical distress, that he did not have a limp or a gait abnormality, and that he walked out of the office favoring neither limb. A second "Contact Form" filled out on July 28, 2000 by the receptionist corroborates Dr. Muenz's description of the foregoing events and also indicates that Claimant requested a copy of his back evaluation, noting that Claimant had already received it on June 29, 2000, and that his attorney received the same on June 7, 2000. A "Patient Contact Form" dated June 29, 2000 indicates that Claimant "picked up copy of records--moving to Tampa." (E-1D; J-1-Muenz at 22-23).

Dr. Muenz was deposed on September 19, 2001. (J-1-Muenz). Dr. Muenz stated that he had ordered Claimant a back brace because Claimant reported previous symptomatic relief from the use of a back brace and that Ms. Wiltshire asked him if he would prescribe or recommend the brace. He then stated that he did not actually recommend a back brace, but that he recommended to Claimant that he see some local prosthetists who deal in off-the-shelf nonprescription back braces. To the best of his knowledge, Dr. Muenz believed Claimant obtained a back brace from one of those prosthetists. Dr. Muenz did not recall writing a prescription for the back brace. *Id.* at 13-14; 24-26. However, the record contains a prescription dated February 18, 2000, from "Florida O & P Services, Inc." diagnosing back pain and prescribing a "Cyber Tech 1000" as "medically necessary." The signature appears to be that of Dr. Muenz. The word "TRIAL" appears on the prescription and is underlined twice. (J-1-Wiltshire, Claimant's Exhibit 2). Dr. Muenz described the events of July 28, 2000 as he had previously recorded them in the related "Contact Form," adding that he was frightened by Claimant's behavior. (J-1-Muenz at 14-17). Dr. Muenz elaborated that he usually conducts depositions in his office, but that his fear of Claimant led him to request that the deposition take place somewhere that would require Claimant, if he were to attend, to walk through metal detectors. *Id.*

at 18-19.[2] Dr. Muenz explained that, after seeing Claimant "storm" out of his office and "bolt" through the parking lot without any altered gait, his opinion "completely changed" in that he no longer believed Claimant had a disability related to his right foot. *Id.* at 19-20, 35-38, 43.

Dr. Muenz explained that when he was conducting his back evaluation, it was intended that he determine whether there was a connection between Claimant's back complaints and his right foot injury. (J-1-Muenz at 51). Upon reiterating his prior findings with regard to Claimant's back, he opined that Claimant had a bad back problem at some point in his life, and that, on a "time-to-time basis" he may have an acute flare up of back pain. *Id.* at 55. Dr. Muenz testified that, while limping can cause mechanical back pain, he does not believe it is within a reasonable degree of probability that Claimant was suffering from mechanical back pain related to his limping. He elaborated, noting that his physical examination of the Claimant did not reveal evidence of significant back problems, but that Claimant reported a history of serious back injury. *Id.* at 57-59.

Dr. Lovejoy also referred the Claimant to the pain clinic at Jacksonville Surgery Center for "evaluation and treatment of a possible complex regional pain syndrome" in his right foot. Dr. Salahi performed the Claimant's "New Patient Evaluation" on February 9, 2000. Dr. Salahi recorded the history of the August 25, 1999 right foot crush injury, and noted that Claimant's past medical history was "unremarkable." Dr. Salahi did not indicate that Claimant complained of any back pain. His evaluation was focused solely on Claimant's right foot, which he diagnosed with causalgia of the right foot and ankle. Dr. Salahi recommended and performed treatment with a series of lumbar sympathetic blocks. From February 23 through April 19, 2000, Claimant received six lumbar sympathetic blocks from Dr. Roberts, board-certified in anesthesia and pain management. The operative reports from the block series do not indicate that Claimant verbalized or visibly exhibited back pain. (See J-1-Roberts at 38-39). In a letter dated April 5, 2000, Dr. Roberts informed Employer's Insurance Carrier, ARMS Incorporated Workers' Compensation, of the Claimant's progress. After describing Claimant as a "pleasant 37-year-old gentleman with chronic right foot pain secondary to a possible complex regional pain syndrome," Dr. Roberts opined that Claimant would benefit from participation in the reflex sympathetic dystrophy program at Genesis Rehabilitation Hospital. (J-1-Roberts, Employee's Exhibits 1,2, and 3).

Contained elsewhere in the record is a letter dated June 6, 2000, composed by Claimant's attorney and signed by Dr. Roberts. The medical opinions expressed in the letter were adopted by Dr. Roberts through his signature. The detailed letter indicates, among other things, that Claimant's complaints of back pain are reasonable in light of his injuries, and that this back pain will progress and spread to other areas of his body. (J-1-Florete, Employer's Exhibit 1).

Dr. Roberts was deposed on September 21, 2000. (J-1-Roberts). When asked whether he recalled Claimant having complaints of back pain, Dr. Roberts replied that, while he remembered Claimant telling him that he did have some back pain complaints, he did not know if he ever documented it because the overriding concern was Claimant's right foot pain. *Id.* at 9-10, 42-44.

[2]The deposition took place at the Duval County Courthouse.

Despite his prior description of Claimant as "pleasant," Dr. Roberts recalled that Claimant "was always a disgruntled individual," and that, "He was angry." *Id.* at 16, 44-45. Dr. Roberts affirmatively stated that Claimant has complex regional pain syndrome, though he had not seen the Claimant since April 9, 2000. Later in the deposition, Dr. Robert's stated that further evaluation would be needed to "solidify" that diagnosis and ensure that there are no other issues. *Id.* at 39-40. Though he did not recall observing Claimant walking and did not know whether he actually walked with an antalgic gait, Dr. Roberts declared that any antalgic gait or walking abnormality will cause back problems and pain. *Id.* at 21-23, 37. Dr. Roberts affirmed that Claimant's degree of symptoms with regard to his back would determine his course of treatment and that the only way to normalize Claimant's gait would be to provide complete relief, which he opined, would not happen. Therefore, Dr. Roberts concluded that Claimant would have an altered gait for the rest of his life with continued back pain. *Id* at 24. Dr. Roberts did not follow-up with Claimant after the last block and, as a result, did not communicate with Dr. Lovejoy after Claimant's treatment at his clinic. *Id.* at 45-46.

At Claimant's attorney's request, Dr. Pohl, board-certified in orthopaedic surgery, performed an "Independent Medical Evaluation" of Claimant on April 5, 2000. (J-1-Pohl). Dr. Pohl's evaluation included an examination of the Claimant in addition to review of specified medical records. Claimant described his right foot injury resulting from the August 25, 1999 incident. Claimant reported that he had been experiencing increasing low back pain since November (1999). Dr. Pohl also noted, "Apparently, he'd been having low back pain for years, but it was on an intermittent basis with intervals of no discomfort. Now, he says his low back pain is constant." Dr. Pohl described Claimant's gait as characterized by a "flat-footed gait on the right without toe off." Upon examination of Claimant's back, Dr. Pohl noted full range of motion of the dorsolumbar spine, complaints of "aching pain" with right and left lateral bending which is located at the T-12, L1 level, and some paravertebral spasm. Dr. Pohl concluded, "based on my review of the records," that Claimant had sustained a severe contusion to his right foot with causalgia. He further opined that Claimant's thoracolumbar pain syndrome has been aggravated by the gait alteration resulting from the injury sustained on August 25, 1999. (J-1-Pohl, Claimant's Exhibit 2). Dr.Pohl's examination of the Claimant lasted from fifteen to twenty minutes. (J-1-Pohl at 34).

Dr. Pohl was deposed on March 20, 2001. (J-1-Pohl). Dr. Pohl reiterated the findings from his April 5, 2000 evaluation. *Id.* at 5-10. Dr. Pohl explained that he had received additional specified medical records on March 14, 2001 to review for the deposition. *Id.* at 14-15. Upon review of a February 17, 2001 MRI of Claimant's lumbar spine and a February 1, 2001 x-ray series, both interpreted by Dr. Zaenglein, Dr. Pohl explained the correlation between his diagnosis of thoracolumbar pain syndrome and the Claimant's MRI and x-rays.[3] During his discussion, Dr. Pohl described the Claimant's previous T12 and L1 compression fractures with changes of degenerative disc disease without herniation or canal stenosis on the inferior end-plate fracture of L1. Dr. Pohl stated that the compression fractures and degenerative disc disease were consistent with his diagnosis

[3]Dr. Zaenglein interpreted the February 17, 2001 MRI as consistent with degenerative disc changes at L1-2 with no central canal stenosis, and he interpreted the February 1, 2001 x-ray series as indicative of mild compression fractures of the thoracolumbar spine. (J-1-Pohl, Claimant's Exhibit 3).

of thoracolumbar pain syndrome, the area in which he detected muscle spasms, and the area in which Claimant complained of pain. (J-1-Pohl at 18-19). Dr. Pohl concurred that the fractures on x-ray were old fractures, stating that degenerative disc disease would be consistent with those old fractures. Dr. Pohl opined that an injury that involved twisting of the spine or a persistently altered gait over a period of time of non-weight bearing and significant gait alteration, could affect one's back and could affect a clinical entity that "may have previously been symptomatic but aggravated." *Id.* at 22. He further opined that Claimant's limping for two-and-a-half to three months by November 1999 would be consistent with his gait aggravating his lower back, and, that at the time of the deposition, Claimant's aggravation was permanent. *Id.* at 24-25. Dr. Pohl declared that Claimant's altered gait was aggravating his degenerative condition in his thoracic lumbar spine. *Id.* at 28.

Dr. Pohl explained that, at the time he performed his evaluation of Claimant and wrote the accompanying report, he "really wasn't aware" of Claimant's prior back injury from the car accident he was in at the age of seventeen. (J-1-Pohl at 29-30). When asked, Dr. Pohl stated that a patient could easily fake a limp, that he had treated patients who had faked a limp or altered gait, and that it was possible that Claimant could have faked a limp or altered gait. *Id*. at 32.

Dr. Hofmann, board-certified in physical medicine and rehabilitation, treated Claimant at the Physical Medicine Specialists of Brooks Rehabilitation from May 2, 2000 through December 10, 2001. (E-1E). During his initial evaluation of Claimant, Dr. Hofmann recorded an accurate history of Claimant's right foot injury, noting that Claimant was "felt to possibly have complex regional pain syndrome." Claimant reported numbness and pain in his thighs following administration of the second in a series of lumbosacral sympathetic blocks. Dr. Hofmann did not record any complaints of back pain. Dr. Hoffman noted a past medical history significant for "a back injury at age 17 in which he fractured three vertebrae and has some lower back pain since then." Dr. Hofmann examined the Claimant and reviewed medical records from Drs. Lovejoy and Muenz. Dr. Hofmann noted that Claimant ambulated with "good contact over the sole of the foot, but had a mild limp and decrease in ankle and foot movement with ambulation." Dr. Hofmann's impression upon examination and review of the medical records before him was: probable complex regional pain syndrome involving the right foot and bilateral thigh pain following lumbosacral block. (E-1E). Dr. Hofmann later explained during his deposition that the bilateral thigh pain was not a diagnosis, but was repetition of the Claimant's complaints to him. (J-1-Hofmann at 9).

Weekly follow-up notes dated from May 9, 2000 through June 13, 2000, indicate that Claimant's pain complaints remained consistent. On June 6, 2000, Dr. Hofmann concluded that Claimant reached Maximum Medical Improvement (MMI). Per Claimant's Functional Capacity Evaluation, he fell within the medium duty work category with no lifting or carrying greater than fifty pounds. (see J-2, Deposition Exhibit 2). Claimant was also to avoid standing/walking greater than forty-five minutes at a time and greater than three hours in a full day of work. Extrapolating from the AMA Guides for the Evaluation of Permanent Impairment, 4th Edition, Dr. Hofmann concluded that Claimant had a 25% permanent partial impairment rating of the lower extremity to account for his condition which converts to a 10% permanent partial impairment rating of the whole person. (E-1E). Dr. Hofmann next treated Claimant on August 21, 2000. Dr. Hofmann noted that "25 minutes

was spent with the patient" who complained of overall increase in his right foot and bilateral thigh pain. He also noted:

> He [Claimant] also reports persistent back pain. He now reports that he was pain free as far as his back since the time of his original back injury at age 17 until his Workers' Compensation injury. This contradicts what I have in my history and physical in which I have documented that he had some back pain since his original back injury.

(J-1-Hofmann, Claimant's Exhibit 1).

Dr. Hofmann next treated Claimant on September 22, 2000. Dr. Hofmann stated the following:

> Mr. Minotis showed a prescription from his primary care physician indicating that over the past 5 years, he has not treated Mr. Minotis for back pain. However, he had a preexistent back injury and it is unclear how symptomatic he was as a result of this.

(E-1E).[4]

Dr. Hofmann next saw Claimant on December 12, 2000, when Claimant complained of increased bilateral thigh pain. Dr. Hofmann increased his medications and noted that Claimant's work restrictions remained unchanged since he had reached MMI. After Claimant's January 29, 2001 follow-up, Dr. Hoffman reviewed Claimant's medical records and expressed doubts that Claimant truly has complex regional pain syndrome (RSD).[5] Accordingly, Dr. Hofmann recommended reducing Claimant's MMI rating to a 20% permanent impairment of the right foot equating to 14% of his right lower extremity. (E-1E, J-1-Hofmann at 21, 27-28 and Claimant's Exhibit 1). A March 1, 2001 follow-up note documents Claimant's report that his primary care physician addressed his back pain and provided x-ray reports. Dr. Hofmann noted that the x-ray reports showed previous fractures at T12 and L1 with severe degenerative disc disease at L1-2 and a cyst on the right S2 nerve

[4]Attached to the deposition of Dr. Florete as part of Employer's Exhibit 1 to that deposition is a treatment note from the Yulee Family Practice Center dated September 18, 2000. In that note, a physician with the initials "JWP" indicated that Claimant's care for a workers' compensation related injury was being managed by another physician and that Claimant "Needs a note to this other physician that I have never treated him for a back related injury." The physician indicated that Claimant was experiencing chronic back pain because of the abnormal gait secondary to global RSD. He also indicated that the note was written as requested. The evidentiary record is devoid of treatment records from "JWP" validating the veracity of statements made in the letter. (J-1-Florete, Employer's Exhibit 1).

[5]During deposition, Dr. Hofmann explained that he doubted the diagnosis of regional pain syndrome because the only objective finding that he found on all his physical examinations was a decrease in temperature with no changes of the skin, of the toenails, or a significant amount of swelling, as would be expected with regional pain syndrome or RSD. (J-1-Hofmann at 27-28).

root. Dr. Hofmann concluded in his note that Claimant's back condition "does not appear to be related to his Workers' Compensation injury." The Claimant was scheduled to see Dr. Nguyen for evaluation. (E-1E). In a May 1, 2001 follow-up note, Dr. Hofmann noted that Claimant was scheduled for diagnostic tests and reiterated that he did not believe that Claimant's back condition is related to his Workers' Compensation injury; however, he remarked that if the tests showed some abnormalities in his right lower extremity, the conditions might be related. *Id.*

Dr. Hofmann saw Claimant for follow-up on June 5, 2001. Dr. Hofmann reviewed the MRI and x-rays performed by Dr. Nguyen, commenting that they showed previous fractures at T11, T12, and L1, a Schmorl's node at L1, and decrease in disc space at L1-2. Dr. Hofmann recorded Claimant's report that Dr. Nguyen feels that his back pain was aggravated by his leg condition.[6] Dr. Hofmann documented his explanation to Claimant that his spine abnormalities preexisted. In a "Conference Note" dated July 16, 2001 Dr. Hofmann indicated that he met with the Claimant's attorney and informed him that he was not sure whether or not the Claimant's back pain has been aggravated by his Workers' Compensation injury since it depends on how symptomatic it was prior to that injury. A September 11, 2001 "Follow Up Note" indicates that Claimant was having another diagnostic work up and treatment at Shands in regards to his back pain. Dr. Hofmann saw Claimant on November 6 and December 10, 2001 for follow up on his chronic foot pain. After noting that Claimant was established with Dr. Florete and was receiving his medications through him, Dr. Hofmann "signed off" his case." (E-1E).

Dr. Hofmann was deposed on February 25, 2002. (J-1-Hofmann). Dr. Hofmann explained that, while he did not believe that he was authorized to treat Claimant's back injury, he understood Claimant's history of preexistent back injury and back pain. *Id.* at 5-6. Dr. Hofmann reviewed his treatment of Claimant, citing which additional pieces of medical evidence he received over time for consideration. *Id.* at 7-14. Dr. Hofmann stated that Claimant always limped in his presence. *Id.* at 18. Throughout the deposition, Dr. Hofmann repeatedly explained that he could not state whether Claimant's current back complaints are causally related to his right foot injury because he does not have enough information to make a connection between the two conditions, noting that correlation depends upon how symptomatic Claimant's back was prior to the foot injury. *Id.* at 6, 16-17, 28-30. Dr. Hofmann explained that it was possible that Claimant's back and thigh pain resulted from the injuries he sustained in a car accident at the age of seventeen and subsequent degeneration. However, he also noted that it was possible that the pain could be explained as the aggravation of those old injuries by his limping or by nerve damage. Dr. Hofmann explained that there were no studies that could be done to "shed light" on which of these three possibilities is responsible for Claimant's back pain. *Id.* at 33-35**.** Dr. Hofmann then reiterated that one of the reasons that he is unable to render an opinion within a reasonable probability regarding any relation between Claimant's back injury and his right foot injury is that he does not know how much back pain the Claimant was experiencing

[6]A treatment note dated May 16, 2001from Dr. Nguyen, neurological surgeon, indicates that the CT scan of Claimant's pelvis and abdomen were read as negative, and that Claimant was returned to Dr. Arce for follow up. Dr. Nguyen made no diagnoses of any kind and did not speak with regard to Claimant's back. (J-1-Florete, Employer's Exhibit 1).

prior to his right foot injury. *Id.* at 36.

On November 28, 2000, Dr. Triggs, Associate Professor in the Department of Neurology at the Shands of University of Florida Neurology Clinic, performed a "compulsory medical examination" of Claimant at Ms. Wiltshire's request. (E-1F). Dr. Triggs explained that Claimant had complaints of two types of pain: burning pain in both legs affecting the anterior and posterior thighs, which began after an injection for the foot, and pain in the right foot. Dr. Triggs noted a past medical history of a motor vehicle accident at the age of seventeen years in which the Claimant thought he may have broken some bones in his back and was required to wear a brace. On examination, Dr. Triggs noted that Claimant had some low back pain. Claimant informed him that he was unsure as to whether this pain is related to his previous motor vehicle accident or is related to his current difficulties brought on by the fact that he walks differently. Dr. Triggs noted, "In detail, Mr. Minotis described the fact that he has to limp and cannot weight bearing [sic] on the right foot." Dr. Triggs also noted that, although Claimant appeared to be in no acute distress, he "ambulated with a very marked limp, favoring the right foot." Dr. Triggs further remarked that Claimant described the limp as typical, and went on to describe considerable hypersensitivity of the foot, pointing out that he does not like to wear shoes because anything rubbing on the foot is extremely uncomfortable. (E-1F).

Besides describing additional medical records available for his review, Dr. Triggs described a surveillance video provided by Employer's insurance carrier and dated August 2000. The video is not in evidence. According to Dr. Triggs, on the tape, Claimant is observed sitting on the beach, moving his feet back and forth and varying his position by crossing and straightening his legs. Dr. Triggs noted that Claimant did not demonstrate any signs of hypersensitivity in those maneuvers. Claimant is also observed ambulating with what appeared to be an inconsistent, but slight, limp favoring the right foot for a "considerable distance on the beach." Dr. Triggs noted that the limp on the video is "of considerable less magnitude than what he demonstrated in [the] clinic today." Claimant is also observed sitting in his vehicle after leaving the beach to pull a sock over his right foot "without any sign of difficulty as one might anticipate in the presence of causalgia." (E-1F).

Based on review of the evidence before him, Dr. Triggs concluded that Claimant's diagnosis was a crush injury to the right foot. Dr. Triggs found no convincing evidence of reflex sympathetic dystrophy, complex regional pain syndrome, or causalgia. From a neurologic standpoint, Dr. Triggs would not apply an impairment rating to Claimant. Regarding any impairment rating assigned to Claimant by orthopaedists based on the degree of bony injury sustained in the right foot, Dr. Triggs stated, "I would assume that these physicians would take into account what appears to be at least some degree of embellishment on Mr. Minotis' part regarding his degree of discomfort." With regard to Claimant's complaints of leg pain, Dr. Triggs found no medical evidence to suggest that any pathological process had spread from his foot to affect his legs. Dr. Triggs declined from speculating about any possible relationship between the administration of lumbar sympathetic blocks and the development of pain in other areas. (E-1F).

On April 6, 2001, Claimant saw Dr. Arce, a board-certified neurosurgeon and Associate Professor in the Department of Neurosurgery at the University of Florida at Shands in Jacksonville,

for a neurosurgical consultation at the request of Dr. Price for low back and leg pain. (E-1G; J-1-Arce at 4). Claimant reported that he suffered a right foot injury a year-and-a-half prior when a bail of hay fell on it, causing him to develop severe burning pain in his foot and low back. He further stated that after receiving the second in a series of sympathetic nerve blocks in March of 2000, he developed severe pain in his lower back radiating down both thighs. Claimant described the pain as constant and worsened by stress, laying down, and resting. Dr. Arce noted that Claimant's past medical history was, "Unremarkable, except for an accident 20 years ago, after which he needed to use a lumbar girdle for about 6 months." Upon physical examination and diagnostic testing, including a lumbosacral spine x-ray and MRI of the lumbar spine showing an old mild compression fracture of L1 with degenerative disc disease of the L1-L2 level with Schmorl's node, Dr. Arce's impression was: chronic low back and leg pain. Dr. Arce found no evidence of nerve root or thecal sac compression at any level. He remarked that the etiology of the pain is unclear, noting that there is no evidence of pathology that could account for the severe pain and that the relationship to the sympathetic block is also unclear. Dr. Arce ordered a CT scan of the Claimant's abdomen and pelvis to rule out a retro peritoneal lesion or any other possible source of Claimant's pain. (E-1G).

On Dr. Arce's referral, the Claimant underwent EMG/Nerve conduction studies at the Shands Jacksonville Health Center/Jacksonville Department of Neurology on April 27, 2001. Dr. Berger, Professor and Chairman of the Department of Neurology, conducted the study. Claimant reported to Dr. Berger a crush injury to the right foot in August 1999. He reported that, after the second in a series of sympathetic nerve blocks in April 2000, he began to experience a deep ache in both legs with weakness most pronounced in the left. Claimant complained of burning of the dorsum of the right foot and aching of the left anterior thigh. He also reported that he has low back pain that radiates across his entire lower back and into the left leg, and worsens from walking for long periods of time. On physical examination, Dr. Berger noted that Claimant's gait was slightly antalgic. Claimant's electrophysiologic study was essentially normal. Dr. Berger found no evidence of significant L/S radiculopathy, plexopathy, or a generalized peripheral neuropathy. (E-1G).

In a June 26, 2001 follow-up, Dr. Arce reported that the Claimant's abdominal and pelvic CT scan was essentially unremarkable, and reiterated his impression of chronic low back and leg pain. He opined that from a neurosurgical point of view, no surgical treatment was indicated. Dr. Arce indicated that Claimant would be referred to Dr. Ero for another opinion and to the Pain Clinic, noting that possible options for consideration would be a dorsal column stimulator or a morphine pump. (E-1G).

Dr. Arce was deposed on March 18, 2002. (J-1-Arce). Dr. Arce reiterated his treatment of Claimant and how he utilized objective testing to rule out nerve injuries and retro peritoneal problems as a source of Claimants pain. *Id.* at 5-9. Dr. Arce explained that he referred the Claimant to Dr. Ero, an orthopaedic surgeon, because he was "puzzled by his [Claimant's] pain," and wanted Claimant to get another opinion. *Id.* at 9. Throughout the deposition, Dr. Arce expressed his inability to determine the source of Claimant's pain. *Id.* at 11-15, 20, 22-24. Specifically, Dr. Arce stated the following with regard to Claimant's pain complaints:

> The thigh pain and the low back pain, I'm not too sure I can explain, you know. I don't have a good explanation for that constant pain that lasts all day long. That doesn't follow any type of pain that I am familiar with unless -- you know, without any structural lesion we can find.

(J-1-Arce at 14).

Dr. Arce ruled out the sympathetic injection as a source of Claimant's pain because there was no evidence of injury or problems stemming therefrom. *Id.* At 12. After establishing that Claimant has had a persistent limp since the time of the foot injury and has degenerative changes at T12 and L1 in his back resulting from prior compression fractures, the following dialogue took place:

> Q: If we put the two together, would you expect that Mr. Minotis' continual limping would aggravate the degenerative condition in his back and maybe produce an orthopaedic condition as opposed to a neurosurgical one?
>
> A: There's a problem**.** The problem that his pain he says is constant even when laying down. I would not expect with somebody having pain and his condition is stable to continue having it when he's laying down. So that's the only reason why I think he's not unstable.
>
> Q: What would be Mr. Minotis' complaints of pain if he had an unstable spine at T12 to L2?
>
> A: Well, it would be back pain. It would be back-- mechanical type pain that is relieved by laying down. Not a pain even when you're laying down or even when you have it (inaudible). That's the only reason that I couldn't understand his pain.
>
> Q: Would you think that pain would be activity related?
>
> A: That's correct.

(J-1-Arce at 22-23).

When asked whether Claimant would "fit the category for somebody with an unstable, lower back condition" in the absence of his complaining about pain when he lays down, Dr. Arce explained that such a scenario would "change everything," and that if Claimant has pain only when he ambulates, one could argue that there is a component of instability. (J-1-Arce at 24).

Claimant began treating at the Institute of Pain Management of Jacksonville, Florida on July

20, 2001, on referral from Shands Hospital for evaluation for a morphine pump versus spinal stimulator. Claimant's "New Patient History and Physical Examination" was performed by Dr. Modi. Dr. Modi recorded a dictated history of the foot injury from the Claimant. Dr. Modi noted that Claimant reported a diagnosis of reflex sympathetic dystrophy. Claimant reported that after the fifth in a series of sympathetic blocks, his pain worsened and he began to have pain "above his knees, shooting up his buttocks and then over time, eventually into his back." Claimant also reported that "he was also limping on his foot for quite awhile, and this may have aggravated his back." Claimant stated that his back pain was evaluated by his family physician, who obtained lumbar spine x-rays and an MRI, and then referred him to Drs. Nguyen and Arce, who told him that his pain was "sympathetic, mediated pain, and a combination of previous compression fractures and disc disease."[7] (J-1-Florete, Claimant's Exhibit 2).

Claimant described his back pain as mostly right-sided lower back pain which is aggravated by a few minutes of sitting, lying down, and prolonged immobility, noting that standing and moving around tends to make it better. Dr. Modi recorded that , "His legs have always been hurting, with symptoms of burning and throbbing. Therefore, he is unable to say if he has any radiation of pain in the legs from his back." Dr. Modi recorded Claimant's past medical history as significant for reflex sympathetic dystrophy of the right foot and compression fracture, T12-L1. On physical examination, Dr. Modi noted that Claimant was in no acute distress and walked with a non-antalgic gait. Dr. Modi reviewed Claimant's February 17, 2001 lumbar spine MRI. Dr. Modi listed "superimposed myofascial pain" under the heading of "Diagnostic Testing" without any explanation, also noting that, per history, Claimant had complex regional pain syndrome, Type 1, involving the right foot.[8] Dr. Florete later concurred at deposition that the diagnosis of complex regional pain syndrome was not confirmed by additional examination or diagnostic testing. (J-1-Florete at 37-38.) Dr. Modi recommended that Claimant see Dr. Florete regarding his pain problem and that he undergo a bone scan of the thoracolumbar spine and ribs. (J-1-Florete, Claimant's Exhibit 2).

Dr. Florete, board-certified in anesthesiology and pain management, saw Claimant on September 11, 2001 for follow up specifically to address the possibility that the Claimant is a candidate for a morphine pump or spinal cord stimulator. Dr. Florete noted that, according to Claimant's records, his medications had not been maximized to the fullest, and, therefore, he would hold off on implantation technology. He also noted that Claimant's August 3, 2001 whole body bone scan showed the presence of early degenerative changes in the lower lumbar spine. (J-1-Florete, Claimant's Exhibit 2, Employer's Exhibit 1). Claimant proceeded to receive follow-up treatment on a monthly basis at Institute of Pain Management from Drs. Modi and Pujol without significant changes in his complaints or condition. (J-1-Florete, Claimant's Exhibit 2). Claimant underwent an

[7]Neither Dr. Arce nor Dr. Nguyen expressed these opinions in any documents of record. Dr. Arce stated in both his treatment notes and at his deposition that he could not opine with regard to the etiology of Claimant's back pain. Dr. Nguyen made no diagnoses with regard to Claimant's back. See fn 6.

[8]During his deposition, Dr. Florete defined myofascial pain syndrome, explaining that it may result from nerve irritation in the presence of a degenerative process or from a change in body mechanics. The record does not indicate which etiology Dr. Modi attributed to this apparent diagnosis. *Id.* at 23-24.

MRI of the thoracic and lumbar spine on December 18, 2001. Dr. Pentlaleri interpreted the MRI of the thoracic spine as evidencing mild degenerative changes of the thoracic spine at T8, T9, T10, T11, and T12 with some end plate irregularities and no evidence of a compression fracture. He interpreted the lumbar spine MRI as evidencing minimal irregularity of the inferior margin of the L1 vertebral body possibly representing post-traumatic change from a compression fracture or degenerative change. (J-1-Florete, Employer's Exhibit 2). After a January 8, 2002, follow-up, Dr. Pujol concluded that, although Claimant exhibited no demonstrable evidence of disc disease in the low back region, he continued to exhibit lower extremity symptoms in a radiculopathic nature as well as greater pain exhibited on forward flexion which tends to lead to discogenic disease. Subsequently, he prescribed a series of three lumbar epidural injections. Dr. Florete administered all three injections, one week apart, from January 28 through February 1, 2002. (J-1-Florete, Claimant's Exhibit 2). Claimant's last follow-up was with Dr. Pujol on February 26, 2002. Claimant reported that his back pain remained unchanged at a level of 8 out of 10 despite stating that his pain medications provided significant relief to his pain level. (J-1-Florete, Employer's Exhibit 1).

Dr. Florete was deposed on February 12, 2002. (J-1-Florete). Dr. Florete reviewed Claimant's medical records from the Institute of Pain Management, noting that Drs. Roberts and Salahi formerly worked at the Institute and treated Claimant after his referral to the Institute by Dr. Lovejoy. *Id.* at 5-19. Dr. Florete adopted as correct Claimant's attorney's statement that Claimant's compression fractures and the degenerative changes at L1 and L2 most likely originated in his motor vehicle accident when he was a teenager, but that the symptoms arising post those conditions may have been accelerated or aggravated by his foot injury of August 25, 1999. *Id.* at 20-21. Later, Dr. Florete affirmatively stated that Claimant's back pain was related to his foot injury, reiterating that the significant symptomology of Claimant's right foot caused him to change body mechanics, and that a change in body mechanics can cause significant alteration in the way that he walked and used his back muscles, which can impact various muscle groups and the spine itself. *Id.* at 29-30. Subsequently, Dr. Florete stated that Claimant's previous back injury was a permanent injury which probably would have caused Claimant back pain throughout his life in periods of exacerbation and remission depending upon factors that would cause exacerbation or the remission. *Id.* at 39. Dr. Florete also opined that it was a possibility that, in the absence of the foot injury, Claimant's back injury pain could have accelerated on its own just due to age and other factors. *Id.* at 44. Towards the end of his deposition, Dr. Florete declared his conclusion that Claimant's right foot injury aggravated his previous back condition. *Id.* at 47.

Dr. Florete explained that the purpose of the epidural steroid injections were to control any nerve root or muscle irritation in Claimant's lower back, that the prescribed TENS unit was intended to help his muscle spasms; and that the medications were palliative. *Id.* at 26. Dr. Florete reiterated that he did not believe Claimant currently needed the spinal cord stimulator or the morphine pump to control his pain. *Id.* at 27. Dr. Florete opined that, at that time, the Claimant was "sitting at MMI," but that such MMI was contingent on continuation of palliative care. *Id.* at 28. Dr. Florete confirmed that Claimant's pain complaints responded to the change medication, the TENS unit, and the injection therapy and that his mechanical back complaints and referred pains from the L1-L2 and L2-L3 dermatomes are in remission. Dr. Florete cited this diminishment in symptomology as the

reason why he no longer recommends an aggressive course of treatment with a morphine pump or spinal cord stimulator. *Id.* at 31-32.

Dr. Florete opined that, after undergoing a work capacity evaluation, Claimant was expected to return to work within the determined restrictions. Dr. Florete opined that Claimant was not capable of working from July 20, 2001 forward, but suspected that would change after the work capacity evaluation. *Id.* at 32-34.[9]

Discussion

A. Section 20 Presumption

Although Employer does not contest that Claimant suffered a work-related injury to his right foot on August 25, 1999, it is Employer's position that the Claimant has failed to establish that his chronic back pain arose from this accident as an aggravation of a preexisting injury. Although Claimant has the burden of establishing the nature and extent of his injury under the Act, Claimant is aided in establishing that his condition arose out of and in the course of his employment by the presumption contained in §20(a) of the Act. *See Trask v. Lockheed Shipyard & Constr. Co.*, 17 BRBS 56 (1980). In order to be entitled to the §20(a) presumption a claimant must demonstrate both that he suffered a physical or mental injury and that working conditions or circumstances existed that could have caused his injury. *United States Industries/Federal Sheet Metal v. Director, OWCP*, 455 U.S. 608, 615 [102 S.Ct. 1312, 71 L.Ed. 2d 495, 14 BRBS 631] (1982). It is well settled that a work related aggravation of a preexisting condition is an injury pursuant to §2(2) of the Act. *Gardner v. Bath Iron Works Corp.*, 11 BRBS 556 (1979), *aff'd sub. Nom., Gardner v. Director, OWCP*, 640 F.2d 1385 (1st Cir. 1981); *Preziosi v. Controlled Industries*, 22 BRBS 468 (1989); *Janusziewicz v. Sun Shipbuilding and Dry Dock Co.*, 22 BRBS 376 (1989) (decision and order on remand); *Johnson v. Ingalls Shipbuilding*, 22 BRBS 160 (1989); *Madrid v. Coast Marine Construction*, 22 BRBS 148 (1989). Moreover, the employment-related injury need not be the sole cause or primary factor in a disability for compensation purposes; if an employment-related injury contributes to, combines with, or aggravates a preexisting disease or underlying condition, the entire resultant disability is compensable. *Strachan Shipping v. Nash, 728 F.2d 513 (5th Cir. 1986); Independent Stevedore Co. v. O'Leary*, 357 F.2d 812 (9th Cir. 1966); *Kooley v. Marine Industries Northwest*, 22 BRBs 142

[9]Claimant submitted post-hearing, a Functional Capacity Evaluation completed by Claimant on May 16, 2002 at the direction of Dr. Florete. The Evaluation was completed by Anita Davis, a physical therapist, at the Brooks Rehabilitation Outpatient Center. Ms. Davis informed Dr. Florete via letter dated May 16, 2002 that, based on Claimant's efforts, he is able to work at the "Sedentary Light Physical Demand Level for activity above the waist." Based on Claimant's performance, Ms. Davis stated that Claimant is able to sit/stand/walk occasionally, he is able to reach and twist occasionally, and he should avoid bending and squatting as he is unable to perform these activities without assistance with his hands. Ms. Davis indicated that Claimant demonstrates fair balance and that his material handling activities should be limited to ten pounds or less due to altered gait with added weight. Ms. Davis noted that Claimant's reported pain level remained at 7 out of 10 throughout the test and that his pain behaviors were "appropriate and correlated with his verbal self report of pain." (Attachment to Employee's Closing Argument).

(1989); *Mijangos v. Avondale Shipyards, Inc.*, 19 BRBS 15 (1986); *Rajotte v. General Dynamics Corp.*, 18 BRBS 85 (1986). Claimant does not have to present medical evidence that working conditions in fact causes his injury; it is enough that Claimant show that there existed working conditions which could have caused the injury. If this threshold requirement is met, the burden shifts to the employer to present substantial evidence to rebut the presumption that Claimant's injury is work-related.

Claimant has established a *prima facie* case to invoke the §20(a) presumption. He has established an injury to his back. Dr. Muenz diagnosed Claimant with a recent flair up of back pain in March 2000. (E-1D). Dr. Pohl diagnosed thoracolumbar pain syndrome, consistent with Claimant's MRI and x-ray evidence of degenerative disc changes and mild compression fractures, and aggravated by Claimant's altered gait resulting from his August 25, 1999 right foot injury. (J-1-Pohl at 18-19, 22, 24-25, 28, Claimant's Exhibits 2 and 3). Dr. Arce diagnosed Claimant with chronic low pain and degenerative changes at T12 and L1 in his back resulting from prior compression fractures. (E-1G; J-1-Arce at 22). An MRI of Claimant's thoracic spine dated December 18, 2001 was interpreted as evidencing minimal irregularity of the inferior margin of the L1 vertebral body possibly representing post-traumatic change from a compression fracture or degenerative change. (J-1-Florete, Employer's Exhibit 2). Dr. Florete opined that Claimant's current back pain is caused by an aggravation or acceleration of his degenerative disc changes, resulting from prior compression fractures, brought on by Claimant's August 25, 1999 foot injury and associated altered gait. (J-1-Florete at 20-21, 29-20, 39, 47). In addition, conditions at work which could have caused this harm. It is undisputed that Claimant suffered a work-related injury to the right foot on August 25, 1999 which has caused Claimant, at least on an intermittent basis, to develop an altered gait. Gait abnormalities can impact muscle groups in the back and the spine itself, and can cause mechanical back pain by accelerating or aggravating existing degenerative changes. (J-1 Muenz at 57-59; J-1-Roberts at 21-23, 27; J-1-Pohl at 22; J-1-Arce at 23; J-1-Florete at 29-30).

B. Rebuttal

To rebut the §20(a) presumption, Employer must present substantial evidence which "establishes a lack of causal nexus" between Claimant's back condition and the August 25, 1999 right foot injury. *Dower v. General Dynamics Corp.*, 14 BRBS 324 (1981). Substantial evidence "is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1084, 4 BRBS 466 (D.C. Cir. 1976). To rebut the presumption, Employer's "evidence must be specific and comprehensive enough to sever the potential connection between the disability and the work environment." *Parsons Corp. v. Director*, 619 F.2d 38, 41, 12 BRBS 23, 235-36 (9th Cir. 1980). However, "conclusive proof" is not required, "merely substantial evidence." *Compton v. Pennsylvania Avenue Gulf Service Center*, 9 BRBS 625, 627 (1979) (It is sufficient that "one could draw a reasonable inference from the evidence that claimant's work environment did not cause his [injury].").

Employer has clearly rebutted the presumption of a causal relationship between Claimant's work-related foot injury and his allegedly subsequent back pain. Dr. Muenz, who examined Claimant on March 9, 2000, speculated that Claimant's recent flair-up of back pain might have resulted from

a strain brought on by his limping. However, on examination, he found no evidence of new back trauma and found no evidence of an aggravation of his previous long-standing back disorder, and therefore opined that Claimant's complaints of back pain were unrelated to his foot injury. Dr. Muenz's conclusion was solidified almost five months later when he observed Claimant walk without any altered gait. (E-1D; J-1-Muenz at 14-20, 35-38, 43, 55, 57-59). Dr. Hofmann concluded that he could not render an opinion with regard to any relationship between the Claimant's foot injury and back pain because the determination of any correlation depended heavily upon Claimant's history of back pain prior to the foot injury, which was unclear due to the lack of objective evidence and Claimant's inconsistent reports. (E-1E; J-1-Hofmann at 5-6, 16-17, 28-30, 33-36). Dr. Arce was also unable to determine the etiology of Claimant's low back pain because the objective evidence did not indicate a nerve injury and Claimant's complaints of constant pain when laying down militated against the conclusion that such pain was related to an unstable spine caused by an antalgic gait. (E-1G; J-1-Arce at 5-9, 14, 22-23). The opinions of Drs. Muenz, Hoffman, and Arce are substantial evidence to rebut the §20(a) presumption.

C. Claimant's Credibility

Once the presumption is rebutted, it drops out of the case, and the record as a whole must be evaluated to determine whether Claimant's back condition arises out of and in the course of his employment at Nassau Terminals, Inc. *See Del Vecchio v. Bowers*, 299 U.S. 280 [S. Ct. 190, 80 L. Ed. 229] (1935); *Volpe v. Northeast Marine Terminals*, 671 F.2d 697,14 BRBS 538 (2d Cir. 1981). Upon review of the record evidence, I find that Claimant's credibility is a significant factor. A study of the medical reports and deposition testimony reveals that Claimant's historic and current pain complaints and accounts of past medical history to various physicians constitute a key factor in their overall assessment of his condition. The record shows that while some physicians felt comfortable relying upon Claimant's subjective complaints and historical accounts, others detected reasons to approach his depictions with a measure of caution or with outright skepticism.

The evidence in this record substantiates the concern of those who were cautious in their reliance upon and consideration of Claimant's subjective complaints and reported past medical history. Physicians customarily and routinely rely upon their patients' descriptions of symptoms and historical accounts in formulating diagnoses and treatment plans. However, when a witness is not credible, his subjective complaints and accounts as a patient are entitled to no greater weight because they have been filtered through a physician or health care professional and appear in a medical report, than a trier of fact might accord his testimony at a hearing. Moreover, it is the province of the trier of fact to assess credibility not the physician. While it appears that Claimant suffered an injury to his right foot on August 25, 1999, and that he continues to suffer some foot discomfort from that injury, there is substantial persuasive evidence in the record that Claimant is not a credible witness either in testimony at hearing or when he describes subjective complaints and past relevant medical history to his various physicians.

As noted by several physicians, Claimant's preexisting back injury was symptomatic prior to the August 1999 foot injury. Claimant was especially inconsistent with his reports of this significant

past medical condition. At his May 2001 deposition, Claimant reported that his prior back injury from the car accident he was in at the age of seventeen required less than two days of hospitalization, only one follow up, and the use of a "girdle," despite injuries consisting of cracks in some of his vertebras. He further testified that he never complained of any back pain at least from 1982 through 1989 when he was married to his first wife. (Minotis Depo. at 5,11,14-17). However, he admitted later in the deposition, that he had felt dull pain in his back prior to the onset of the back pain in November 1999 he attributes to his August 1999 foot injury. *Id.* at 49. Nevertheless, at the April 2002 hearing, Claimant stated that, although he had to wear a back brace "on and off" for several months following the car accident in his late teens, he "never had any follow up treatment," never had any physical therapy," and "never went back to a doctor ever since then" for his back condition. (Tr. 31-32). In March 2000, Claimant informed Dr. Muenz that the car accident left him with three cracked vertebrae requiring a two week hospital stay, bed rest for several additional weeks, the use of a "girdle," and routine follow-up care for six months**.** Claimant also reported that he "always" had back problems since that injury. (E-1D).

Claimant initially informed Dr. Hofmann that he suffered a back injury at age seventeen in which he fractured three vertebrae and had some lower back pain since then. However, Claimant later informed Dr. Hofmann that he was pain free since the time of the original back injury. Dr. Hofmann noted the contradiction between Claimant's reports in his August 21, 2000 treatment note. Approximately one month later, Dr. Hofmann noted that Claimant brought him a prescription from his primary care physician stating that he did not treat Claimant for back pain over the last five years, expressing some doubt with regard to its veracity by noting that Claimant had a preexistent back injury of unclear symptomatology. (E-1E; J-1-Hofmann, Claimant's Exhibit 1). Dr. Triggs was informed by Claimant only that he had been in a car accident at the age of seventeen which might have resulted in some broken bones in his back and required the use of a brace. (E-1F). Claimant informed Dr. Arce of an "accident" twenty years prior to the examination that resulted in his use of a lumbar girdle for approximately six months. (E-1G). Claimant never reported the prior back injury to Drs. Lovejoy, Salahi, Roberts, Pohl, Modi, or Florete. (E-1C; J-1-Roberts, Employee's Exhibits 1, 2, and 3; J-1-Pohl at 29-30, Claimant's Exhibit 2**;** J-1-Florete, Claimant's Exhibit 2). However, Dr. Pohl noted in his evaluation report that Claimant reported a history of intermittent low back pain. (J-1-Pohl, Claimant's Exhibit 1).

Because Claimant's prior back injury and the extent to which its symptomatology has persisted is factual evidence necessary to a determination with regard to the etiology of Claimant's current back pain complaints, and Claimant clearly has not been forthright with regard to that injury, to the extent that a physician relied upon Claimant's account of his preexisting back injury, rather than objective medical evidence thereof (e.g. MRI, x-ray), and subsequent pain complaints, or lack thereof, in formulating an opinion concerning the diagnosis, treatment, or etiology of his current back pain, the weight accorded to that opinion must be diminished accordingly. This is not to say that Claimant is currently pain free with regard to his lower back. However, Claimant has exhibited a proclivity to minimize the severity of his prior back injury and provide inconsistent accounts of resultant pain when he describes his past medical history, and this seriously undermines the opinion of any doctor who relied exclusively upon Claimant's own description of that back injury and subsequent condition in

rendering an evaluation of his current back condition.

Moreover, at least two physicians surmise that Claimant's antalgic gait is, to an extent, fabricated. While Dr. Triggs described Claimant's limp as "exaggerated," Dr. Muenz observed it to be entirely absent as of July 28, 2000. (E-1D; E-1F; Muenz 19-20, 22-23, 35-38). Further, Dr. Roberts admitted that he had never observed Claimant walk and did not know whether he walked with an antalgic gait, and Dr. Modi noted in his examination report of July 20, 2001 that Claimant walked with a non-antalgic gait (J-1-Roberts at 21-23; J-1-Florete, Claimant's Exhibit 2). Because the video upon which Dr. Trigg's based his opinion is not of record, because the veracity of Dr. Muenz's observations are questioned by Claimant, and because Drs. Roberts and Modi are the only physicians of record to never have observed Claimant walk with an altered gait, I find it difficult, without more evidence, to determine the degree to which Claimant's gait is altered, if any.

D. Back Aggravation

The Claimant argues that his preexisting low back condition was aggravated by the compensable right foot injury he sustained on August 25, 1999. The Employer argues that Claimant's work-related right foot injury did not result in any injury or permanent aggravation to his back; any continuing back pain is due to his teenage car accident. Employer further asserts that if Claimant's aggravation argument is correct, then Section 8(f) limiting liability is applicable. In determining whether the August 25, 1999 incident caused any back injury or aggravation of a preexisting condition, the objective medical evidence in the record has been carefully considered. Since the presumption is no longer applicable, the burden of proof in respect to causation remains with Claimant. On this record, this tribunal is unable to conclude that he has established that any of his subjective back pain complaints or any of the objective signs of low back pathology on the recent clinical tests are caused, related to, or aggravated by the August 25, 1999 work-related right foot injury.

The record shows that since his early November 1999 release from the care of Drs. White and Carrasquillo, neither of whom treated him for back pain, Claimant has been examined by or sought treatment from, at least, two orthopaedic surgeons, a neurologist, a neurosurgeon, two dually-qualified anesthesiologists and physicians of pain management, two physicians of physical medicine and rehabilitation, and three physicians whose credentials are not of record. I have reviewed the extensive medical evidence in this case, reexamining several times each medical opinion to determine whether the medical experts have reached a consensus regarding the etiology of Claimant's back condition.

Dr. Lovejoy was the first orthopaedic surgeon to examine Claimant and the first physician to whom Claimant complained of low back pain. Dr. Lovejoy first examined Claimant on November 12, 1999, the same month in which Claimant alleges to have first experienced low back pain. Nevertheless, despite filling out his own new patient entry form, Claimant did not indicate to Dr. Lovejoy that he was currently experiencing any pain beyond his right foot and calf, despite Dr. Lovejoy's being the appropriately credentialed physician to express such pain concerns to. Instead,

Claimant waited until February of the following year, after three additional visits, to inform Dr. Lovejoy of his low back pain. Moreover, Claimant never informed Dr. Lovejoy of his prior back injury. Dr. Lovejoy never treated Claimant for back pain and did not opine with regard to any etiology of that pain in the four months that he cared for Claimant. Approximately two years later, when specifically asked with regard to the etiology of Claimant's back pain, Dr. Lovejoy was only able to opine that Claimant's altered gait related to his right foot injury and could cause some aggravation to a preexisting back condition. Because he had no knowledge of the specifics of Claimant's prior back injury, he could not further speculate with regard to any connection between Claimant's foot injury and current back pain. Therefore, because he had no direct or indirect knowledge of Claimant's prior back injury, and reasonably concluded that such information was necessary to even speculate with regard to the etiology of Claimant's back condition, Dr. Lovejoy's opinion is well-reasoned based on the medical evidence before him and the absence in the record of reliable evidence pertaining to Claimant's back condition prior to the August 1999 foot injury. It is, therefore, entitled to substantial weight.

On the other hand, Dr. Pohl, also board-certified in orthopaedic surgery, examined the Claimant once in April 2000 for approximately fifteen to twenty minutes and concluded that Claimant's altered gait was aggravating his degenerative back condition. At the time of his evaluation, Dr. Pohl had no knowledge of Claimant's prior back injury, but understood that Claimant had a history of intermittent low back pain. Dr. Pohl also understood that Claimant's current chronic back pain had begun in November 1999. Despite noting only that Claimant had full range of dorsolumbar spine motion, subjective pain complaints at the T-12, L1 level, and some paravertebral spasm, Dr. Pohl concluded from his examination and review of medical records that Claimant's thoracolumbar pain syndrome has been aggravated by the gait alteration resulting from the August 25, 1999 right foot injury. However, these medical records did not include any x-rays or MRI's of Claimant's back and only included records from Drs. Lovejoy, Carrasquillo, and Salahi, none of whom were aware of Claimant's prior back injury. Moreover, approximately one year later, Dr. Pohl received additional medical evidence prior to his deposition which evidenced that his diagnosis of thoracolumbar pain syndrome was consistent with Claimant's prior back injury and related degeneration. Nevertheless, despite stating only that a persistently altered gait "could" or "would" be consistent with aggravation of Claimant's lower back, Dr. Pohl, without reference to any objective evidence other than Claimant's alleged altered gait, and without discussing the significance of Claimant's prior back injury and history of intermittent back pain, continued to conclude that Claimant's altered gait was aggravating his degenerative thoracolumbar spine condition.

Dr. Pohl's opinion is entitled to little weight because it is not well-reasoned. Dr. Pohl failed to identify any evidence or rationale supporting his conclusion that, because an altered gait could or would affect one's back, such relationship existed in the Claimant's case. And, curiously, Dr. Pohl admitted at deposition that it was possible that Claimant's altered gait was fabricated, thereby undermining his opinion that Claimant's back pain was entirely due to his altered gait. Moreover, Dr. Pohl stated that Claimant's previous compression fractures and degenerative disc disease were consistent with his diagnosis of thoracolumbar pain syndrome, essentially rendering an etiologic determination entirely distinct from Claimant's right foot injury and altered gait. Dr. Pohl never

explained why this independent etiology was not, in his opinion, the sole or a possible cause of Claimant's current back pain. On the whole, Dr. Pohl failed to consider the significance, if any, of Claimant's prior back injury and his history of low back pain. Accordingly, while no consensus was reached by the orthopaedic surgeons with regard to the etiology of Claimant's back pain, the better reasoned opinion of Dr. Lovejoy suggests that such an etiology cannot be identified based on the evidence of record.

Claimant vaguely informed Dr. Triggs, a neurologist, of his prior back injury and described his primary complaints as limited to right foot and bilateral thigh pain. Dr. Triggs independently noted some low back pain. While Claimant vocalized his own summations with regard to his back pain, his limping, and the extreme discomfort he experienced due to the August 1999 foot injury, Dr. Triggs described Claimant as being in no acute distress. Moreover, a video depicting Claimant experiencing far less discomfort and exhibiting a less severe limp while at the beach indicated to Dr. Triggs that Claimant embellished his degree of discomfort. Based on his examination of the Claimant and review of medical evidence provided by Drs. Lovejoy, Carrasquillo, Hofmann, and Pohl, Dr. Triggs found no medical evidence to suggest that a pathological process had spread from Claimant's right foot into his legs. He gave no direct basis for the origin of Claimant's current low back pain, which was not emphasized by the Claimant during the examination. Accordingly, while Dr. Triggs did not provide an opinion with regard to the etiology of Claimant's back pain, his opinion provides a well-reasoned analysis of objective medical evidence with regard to the spreading of any pathological process from Claimant's foot up his legs and substantiates any doubts that other physicians might have with regard to Claimant's apparent embellishment of his discomfort due to both his right foot injury and back pain.

Dr. Arce, board-certified in neurosurgery, specifically examined Claimant for his low back and leg pain in April and June of 2001. Claimant under-reported the severity of his prior back injury, informing Dr. Arce only that he had been in an "accident" twenty years prior which required him to use a lumbar girdle for six months. Claimant reported that his back pain was intensified by stress, laying down, and resting. After examination and diagnostic testing including an MRI and x-rays of Claimant's spine, EMG/Nerve conduction studies, and a CT scan of Claimant's abdomen and pelvis, Dr. Arce was unable to determine an etiology for Claimant's low back and leg pain, explaining that there was no evidence of nerve root or thecal sac compression, no neurological sources of Claimant's pain, and no other possible sources of Claimant's pain.

Approximately one year later, in March 2002, Dr. Arce stressed that he could not opine with regard to an etiology because Claimant's pain purportedly lasted all day long and he had no structural lesion. Dr. Arce ruled out a mechanical cause for Claimant's back pain because pain caused by an unstable spine is alleviated by lying down, and Claimant's back pain continues and worsens when lying down. Accordingly, based on Claimant's subjective complaints and specified objective medical evidence, Dr. Arce ruled out, in his reports and deposition, both a neurological and a mechanical source of Claimant's back pain, and concluded that he was unable to identify an etiology. Dr. Arce's well-reasoned and documented opinion that the etiology of Claimant's back pain is indeterminate is consistent with the entirety of the medical evidence of record and is therefore entitled to substantial

weight.

Drs. Roberts and Florete, both board-certified in anesthesiology and pain management, along with three physicians of unknown qualifications, Drs. Salahi, Modi, and Pujol, treated Claimant for possible complex regional pain syndrome or reflex sympathetic dystrophy in his right foot. Claimant first treated with Drs. Salahi and Roberts from February through April of 2000. The records from Dr. Salahi's examination of Claimant and Dr. Roberts's subsequent administration of lumbar sympathetic blocks do not indicate that Claimant ever reported a history of a back injury or complaints of back pain. Nevertheless, when Dr. Roberts was deposed in September 2000, he stated that he remembered Claimant complaining of back pain. This is only one of several inaccuracies in Dr. Roberts's opinion. I, therefore, give his opinion little weight.

In April 2000, Dr. Roberts described Claimant as a "pleasant" gentleman when writing to Employer's Insurance Carrier. However, at the September 2000 deposition, Dr. Roberts, without being asked with regard to Claimant's personality, described Claimant as "angry" and "always disgruntled." Despite admitting to having never seen the Claimant walk, and despite Dr. Salahi's failure to describe Claimant's gait, at his deposition, Dr. Roberts concluded that Claimant would have an altered gait for the rest of his life with continued back pain because, "Any antalgic gait or abnormality in the way you walk is going to cause more back problems and further back pain." (J-1-Roberts at 23). Therefore, without documenting any of Claimant's back complaints including the type, location, and duration, without knowing whether and to what degree Claimant limped, and without knowledge of Claimant's prior back injury, Dr. Roberts felt justified in concluding that Claimant's low back pain is due to his permanent antalgic gait. Dr. Roberts's opinion is not well-reasoned, not documented, and not based on objective evidence. Rather, it appears that Dr. Roberts assumed, based on his diagnosis of complex regional pain syndrome in Claimant's right foot, that Claimant would have a permanent limp, which in turn, would cause back pain. Even Dr. Roberts's assumptions are unfounded, because he had yet to "solidify" the diagnosis of complex regional pain syndrome. Accordingly, Dr. Roberts's opinion with regard to the etiology of Claimant's low back pain is entitled to little weight.

Claimant treated with Drs. Modi, Pujol, and Florete at the Institute of Pain Management from July 2001 through February 2002. While Claimant reported many things to Dr. Modi during his initial evaluation, he did not report his prior back injury. Dr. Modi identified evidence of that prior injury through the February 17, 2001 MRI results. Claimant reported that his current back pain was aggravated by sitting, lying down, and prolonged immobility. Dr. Modi noted that Claimant was in no acute distress and walked with a non-antalgic gait. Dr. Modi did not opine with regard to the etiology of Claimant's back pain, and, instead, referred him to Dr. Florete. Thereafter, Drs. Florete, Pujol, and Modi treated Claimant. None of the three physicians opined with regard to the etiology of Claimant's back pain in any of their follow-up notes.

Dr. Florete was the only physician deposed from the Institute of Pain Management. Although none of the physicians with whom he worked noted that Claimant walked with an antalgic gait, and Dr. Florete's only knowledge of Claimant's prior back injury came from MRI evidence which did not

include any description of past symptomology, Dr. Florete concluded that Claimant's right foot injury aggravated his preexisting back condition. Dr. Florete stated, without any factual support, that Claimant's right foot symptomology caused him to change body mechanics. Dr. Florete then stated that is was possible for a change in body mechanics to cause alteration in the way Claimant walks and uses his back muscles. He then stated that such alterations can impact muscle groups in the back and the spine itself. Dr Florete's opinion is not well-reasoned because he failed to provide any rationale for his ultimate conclusion that what "can" happen when one has significant foot symptomology actually did happen to the Claimant. Moreover, Dr. Florete admitted that it was also a possibility that Claimant's back pain could be due to an acceleration of his prior injury due to age and other factors unrelated to his foot injury. And, significantly, Dr. Florete did not rule out this possibility despite acquired knowledge of the severity of Claimant's past back injury from the December 18, 2001 MRI. Additionally, Dr. Florete attempted to attribute Claimant's back pain to both mechanical and dermatomal (neurological) conditions by explaining that his prescribed therapies and medication for Claimant had put those complaints in remission. However, there is no evidence in Dr. Florete's records that Claimant actually suffered from such diagnosed pain sources, and Claimant's level of reported back pain remained insignificantly changed throughout those treatments despite alleged improvement. Dr. Florete's dismissal of Claimant's significant prior back injury without any discussion in favor of a speculative diagnosis based only on the fact that Claimant had right foot symptomology does not amount to a well-reasoned opinion. Therefore, the speculative opinions of Drs. Roberts and Florete are entitled to less weight because neither was able to support his conclusion with a rationale supported by the evidentiary record and the objective evidence before them.

Dr. Hofmann, board-certified in physical medicine and rehabilitation, treated Claimant for approximately one and one-half years, far longer than another other physician of record. When Dr. Hofmann began treating Claimant in May 2000, Claimant reported the history of his prior back injury and noted that he had experienced back pain since then. Claimant did not report persistent back pain until August 2000, however, at the same time, Claimant insisted that he was back pain free since the time of his original back injury, contradicting his prior reports to Dr. Hofmann. A letter from Claimant's physician, written at Claimant's request after the August 2000 examination, indicating that he had not treated Claimant for back pain in five years, further confounded Dr. Hofmann with regard to the level of Claimant's pre-existent back pain. After reviewing specified x-ray and MRI reports and of Claimant's back indicating , among other things, compression fractures and severe degenerative disc disease, Dr. Hofmann opined in March, May, and June 2001 that Claimant's back pain did not appear to be related to his foot injury.

Dr. Hofmann explained the significance of Claimant's failure to provide a reliable report of his prior back symptomology during his February 2002 deposition. Though knowledgeable of the extent of Claimant's prior back injury, his August 1999 foot injury, and the resultant limp, Dr. Hofmann was unable to opine with reasonable medical certainty any relationship between Claimant's right foot injury and his current back pain because any correlation would depend on how symptomatic Claimant's back was prior to the foot injury. Dr. Hofmann treated Claimant for the longest period of time out of all the physicians of record, and therefore had the rather unique opportunity to both observe Claimant and review his accumulating medical records. This constant contact enabled Dr.

Hofmann to measure Claimant's credibility against his subjective complaints and objective condition. Dr. Hofmann's conclusion that he is unable to render an opinion within a reasonable probability regarding any relation between Claimant's back injury and his right foot injury because he does not know how much back pain the Claimant was experiencing prior to his right foot injury is especially well-reasoned in light of the objective and subjective medical evidence of record and is entitled to substantial weight. It is obvious to Dr. Hofmann, that, if Claimant was experiencing similar back pain prior to his foot injury, or any degree of back pain for that matter, such pain points to an etiology, at least in part, unrelated to Claimant's right foot injury.

Dr. Muenz, board-certified in physical medicine and rehabilitation, performed a comprehensive back evaluation on Claimant in March 2000. Claimant provided Dr. Muenz the most severe account of his prior back injury and reported that he has had back problems since that injury. Dr. Muenz noted that, while Claimant ambulated freely about the room without any assistive devices, his gait was slightly antalgic. Based on a complete examination indicating, among other things, full range of motion in the cervical and lumbar spine, normal paraspinal muscles in the posterior thoracic spine, no frank muscle guarding or spasm in the lumbar paraspinal muscles, Dr. Muenz concluded that, while Claimant might have recently strained his back while favoring his lower limb, there was no evidence by history or physical examination of a new back trauma or an aggravation of a previous longstanding disorder. The record indicates that after this back evaluation, Claimant and Dr. Muenz had a falling out related to Claimant's pursuit of his medical records and the origin of the back brace he received in connection with his first examination by Dr. Muenz related to his foot injury. Regardless, Dr. Muenz's opinion that there was no clinical evidence of a recurrent back injury, nor of a new injury, nor of an aggravation of his previous and long-standing back disorder is reasoned based on the objective and subjective evidence before him and consistent with the evidence of record as a whole. Therefore, Dr. Muenz's opinion is entitled to some weight to the extent that it supports a conclusion that Claimant's preexisting back condition was not further aggravated by Claimant's right foot injury.

Upon review of the conflicting medical opinions regarding the etiology of Claimant's present back condition, I find that Drs. Hofmann and Arce have, to a more comprehensive degree than the other medical experts, specifically and carefully compared the clinical data related to Claimant's preexisting condition with Claimant's post-August 25, 1999 clinical data and subjective complaints of back pain. Dr. Hofmann's regular treatment of Claimant over the course of a year and one-half enabled him to both reflect upon substantial amounts of objective and subjective evidence of Claimant's overall back condition and consider Claimant's proclivity to manipulate his evidence of pain related to his preexisting back injury. Claimant's failure to provide a credible account of pain related to his preexisting back injury thwarted any attempts by Dr. Hofmann to determine whether or not that injury was in any way aggravated by Claimant's August 1999 right foot injury. Dr. Arce also was unable to render an opinion with regard to the etiology of Claimant's back condition. However, Dr. Arce relied less on Claimant's credibility with regard to his prior injury and more on objective medical evidence and Claimant's subjective complaints. None of that evidence supported a finding that Claimant's back pain was neurological in origin or related to Claimant's right foot injury in a mechanical sense. Rather than speculating with regard to the credibility of Claimant's current

subjective back pain complaints, Dr. Arce chose to remain indeterminate, as the facts before him dictated.

Though Drs. Lovejoy and Muenz did not have the opportunity to review substantial amounts of objective and subjective evidence pertaining to Claimant's current back pain and prior back injury, both physicians provided well-reasoned opinions consistent with and supportive of those of Drs. Hofmann and Arce. Like Dr. Hofmann, Dr. Lovejoy failed to attribute any relationship between Claimant's right foot injury and an aggravation of his preexisting back injury. Dr. Muenz, like Dr. Arce, relied more heavily on Claimant's objective condition and subjective accounts. Dr. Triggs opinion corroborates the findings of Drs. Arce and Muenz with regard to the lack of objective evidence indicating that Claimant's right foot pathology spread upward in a neurological manner.

I give less weight to the opinions of Drs. Pohl, Roberts, and Florete because they are not well-reasoned and are not supported by the objective evidence of record. Rather than comprehensively evaluating the Claimant's condition based on the evidence before them, these physicians apparently ignored Claimant's clinically documented prior back injury and subjective complaints of increasing back pain when not subject to any possible agitation by an uneven gait. Though all three physicians may be correct in stating that a person with an altered gait can experience resultant back pain if they have a preexisting back condition, none of these physicians were able to demonstrate that this relationship occurred in the Claimant.

For all the foregoing reasons, I conclude that the evidence fails to establish that Claimant's August 25, 1999 right foot injury caused an aggravation of his preexisting back injury.

ORDER

It is ordered that the claim for further benefits by Mark Minotis be, and hereby is, denied.

A

JOHN C. HOLMES
Administrative Law Judge